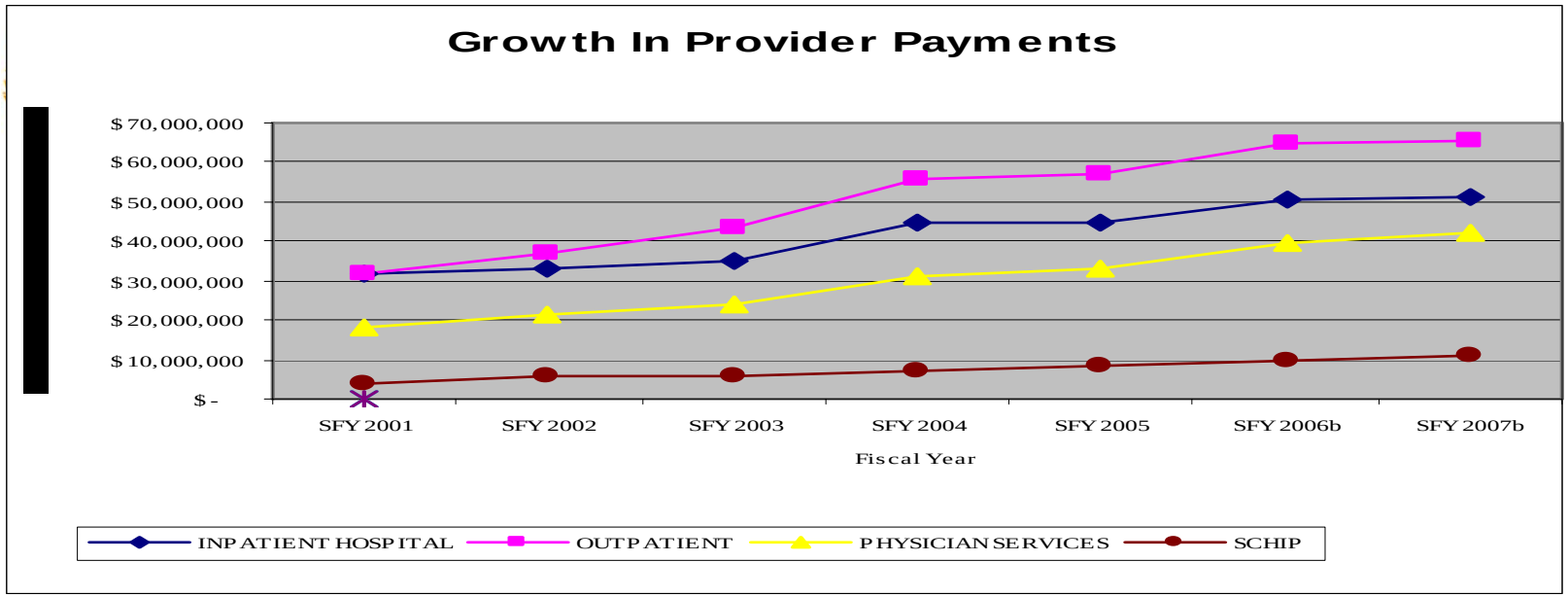
NH Department of Health and Human Services

GRANITECARE HB2
Enhanced Care Coordination Project

John A. Stephen
Commissioner



Expenditures						
	SFY 2001	**SFY 2002**	**SFY 2003**	**SFY 2004**	**SFY 2005**	**SFY 2006b**
INPATIENT HOSPITAL	$ 31,586,112	$ 32,946,609	$ 35,096,862	$ 44,489,884	$ 44,769,951	$ 50,278,261
OUTPATIENT	$ 31,771,117	$ 36,710,787	$ 43,341,308	$ 55,525,461	$ 56,891,886	$ 64,840,000
PHYSICIAN SERVICES	$ 18,358,285	$ 21,566,569	$ 24,124,236	$ 31,172,187	$ 33,324,960	$ 39,455,356
SCHIP	$ 3,784,383	$ 5,878,452	$ 5,776,772	$ 7,309,691	$ 8,367,001	$ 9,992,991
Growth Rate						
		SFY 2002	**SFY 2003**	**SFY 2004**	**SFY 2005**	**SFY 2006b**
INPATIENT HOSPITAL		4.3%	6.5%	26.8%	0.6%	12.3%
OUTPATIENT		15.5%	18.1%	28.1%	2.5%	14.0%
PHYSICIAN SERVICES		17.5%	11.9%	29.2%	6.9%	18.4%
SCHIP		55.3%	-1.7%	26.5%	14.5%	19.4%

Provider Payment Drivers

Number of Enrollees X Price X Utilization

Medicaid is an entitlement serving All eligible comers …

5% Case Load Growth

Price changes for inpatient, outpatient services, and pharmaceuticals

Specific rate increases implemented. Rates need to be monitored closely due to impact on integrity of provider network.

Drives most of change in average cost

Can we have a positive impact here on quality of care and savings?

Medicaid Cost Containment: What Other States Have Done

- "The Kaiser Commission on Medicaid and the Uninsured" highlights actions by states to contain Medicaid costs (http://www.kff.org/medicaid)
- Measures enacted
  - Control drug costs
  - Reductions in or freezing of provider payments
  - Reductions in or restructuring of eligibility
  - Reductions in benefits
  - Increases in co-payments
  - Disease management
  - Long term care reform

What is NH doing to contain Medicaid costs?

- Pharmacy Benefit Management
- Disease Management
- Radiology Prior Authorization
- LTC reform
  - LTC Assessment Tool
- MMA Part D – Clawback calculation
- Service Link Single Point of Entry
- Behavioral Health Evidence Based Practice
- NH has NOT reduced eligibility or benefits

SFY 06-07 Budget Contingency Plan Requested by Joint House/Senate Finance March 10, 2005

OMBP-11: Implement care management
SFY06 general funds- $0
SFY07 general funds- $3,389,838

- Implement a care management program, as envisioned in GraniteCare, that supports the efficient and effective delivery of primary and specialty care services focused on prevention and each client having a medical home. Care management incorporates disease management activities. The Department is working with an external advisory group to explore three program models and options. This could be implemented by July 1, 2006. Estimated savings of 5% on program costs is based upon reported results in other states that implemented a managed care or primary care case management type delivery system. Thus the estimates for 2007 are calculated from 5% of provider payments, Fund Code A, inclusive of other initiatives.

HB 2, 2005 177:123 I and II
The Department shall:

- Establish and implement a care management program focused on prevention
- Explore cost effectiveness of care coordination vendor contract to provide comprehensive care coordination services
  - Coordinate existing benefits' management contracts
  - High cost, high complexity case management using predictive modeling and individualized intervention plan
  - Linkages to other parts of the department
  - Coordination of primary medical care and mental health care

HB 2, 2005 177:123, III

- Explore primary care case management (PCCM) payment methodology as pilot
  - Medical homes
  - Patient education
  - After hours nurse support and triage systems
  - Recipient incentives
- Increase the use of evidence-based medicine
- Explore feasibility of pay for performance reimbursement methodology
- Explore implementing client incentive pilot
- If needed and with legislative approval, enter into waiver agreement with CMS

Next: Comprehensive Care Coordination

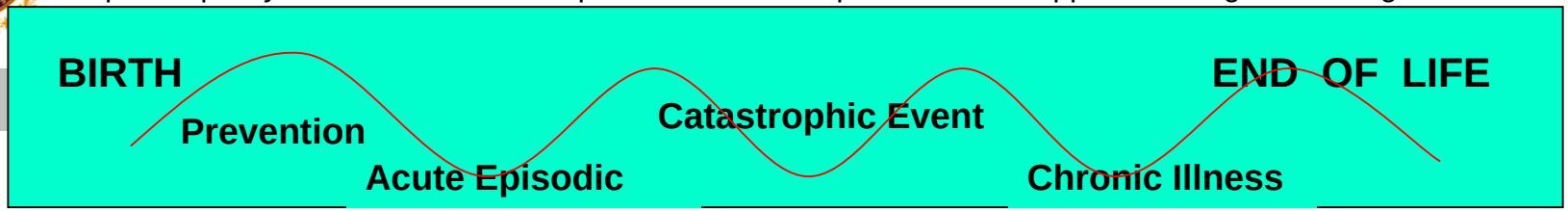
- Next logical step to support on-going efforts to control costs in an expanding health care environment and providing a more rational basis for encouraging/guiding the delivery of cost effective care.
- Opportunity to investigate a variety of approaches
  - Purchase administrative services borrowed from private sector
  - Improve quality of care
  - Improve health outcomes through prevention
  - Ensure connectivity between PCPs, Specialists and Mental Health providers for clients with complex medical needs
- Creates flexible benefits management structure
  - Adapt to changes in policy, best practices

NH DEPARTMENT OF HEALTH AND HUMAN SERVICES

GRANITECARE/HB 2 ENHANCED CARE COORDINATION

Comprehensive, patient-centered medical management and care coordination to optimize health outcomes, improve quality of services, enhance provider relationships and realize approved budgeted savings.

SCOPE:



PORTFOLIO OF TOOLS:

Disease Management
(McKesson)

Pharmacy Benefits Management
(First Health Services Corporation)

Acute Services Utilization Management

- Prior Authorizations
  - Elective Inpatient Admits
  - Acute Rehab Admits
  - Transplants
  - DME and Medical Tech
  - Out of state admits
  - Radiology Services
- Centralized clinical review and standard guidelines/evidence based practice
- Integration Primary Care and Mental Health Services

Outpatient Utilization Management

- Individualized care coordination of high cost patients & others identified through predictive modeling or other tools
  - Establishment of Medical Homes
  - Health Risk Assessments
  - Coordinated Medical Services
  - Client Incentive Program
  - 24 Hour Nurse Advice Access
  - Integration with other DHHS bureaus and community based programs

Other Administrative Services

- Member Services
  - Health Literacy
  - Client satisfaction
- Provider Network Development and Management
  - Ensuring access
  - Pay for Performance
  - Provider satisfaction
- Quality Management and Improvement
  - EQRO
  - Benchmarking, performance standards and outcomes measurement

Services noted are examples and subject to modification by NH DHHS

Fiscal Committee Approval
January 23, 2006

- DHHS received approval to implement the care management pilot for all Medicaid recipients who are in the APTD (Aid to the Permanently and Totally Disabled) program and recipients who are eligible for Medicaid via the TANF eligibility.
- Excluded from the pilot:
  - Non-APTD seniors in Old Age Assistance Program
  - Katie Beckett children and Children with Severe Disabilities
  - Children in Foster Care
  - MEAD only eligible adults
  - Recipients in the Aid to the Needy Blind Program
  - Qualified Medicare Beneficiaries

Scope of Services
Will Include

Care Management

* Identifying high-cost, high-risk clients with complex health care needs through the use of dashboard indicators, predictive modeling, co-morbid conditions, claims analysis and health risk assessments;
* Enhanced, proactive, individually designed interventions by clinical staff with providers, clients and family members using case tracking to ensure timely and accurate communications;
* Promoting the adoption of clinical best practices in conjunction with the existing disease management contract.

Scope of Services
Will Include

Concurrent and retrospective inpatient hospitalization review:

On-site inpatient hospital review by clinical staff which will allow for more timely and effective communication with clients, providers and hospital staff; management of DRG outliers; review of one-day hospital stays and readmissions and ensuring access to appropriate home health care services.

Guiding Principles

- Better management of program
- Improved quality of service and care
- Improved health outcomes

Scope of Services
Will Include

Drug Utilization Management

Physician profiling for high cost or abnormal pharmaceutical practice patterns based on standards/algorithms established by identified and certified clinical practice standards. Utilization review of individual recipient polypharmacy drug regimens based on high cost and identified and certified clinical standards.

Scope of Services
Will Include

Outpatient utilization management:

The monitoring and review of emergency room utilization with the primary focus on the use of emergency room setting for primary care visits as well as emergency room visits that might have been prevented through better management of chronic conditions and/or education of clients; and

The establishment of primary care medical homes; establishment of a 24 hour nurse advice telephone resource; updating of existing prior authorization functions to reflect best practices including establishing web based prior authorization process for providers.

Scope of Services Will Include

Perinatal care management

Identification of women at high risk for untoward health outcomes including low birth weight infants through health risk assessments, predictive modeling and claims analysis; development of individual intervention care plans and care coordinators to assist clients to mitigate risk; provider and client education; facilitating referrals and receipt of services from the Department's home visiting programs and postpartum outreach activities.

The scope of services may also include the following components, if it is proven to be cost effective.

Provider network development and management

Assessing existing network capacity to identify gaps in coverage; establishing direct provider telephone access; carrying out provider relations' activities and making recommendations for improving provider relations.

Member services

Providing education to clients as part of the care management process; establishing a call center and working with the Department to establish client profiles to support the implementation of an incentive program aimed at supporting health promotion and prevention efforts.

May Also Include

Integration of contracts - coordination of existing benefits' management contracts including disease management, pharmacy benefit management and radiology services utilization management in a phased in approach to reduce administrative expenses; the establishment of necessary data system interfaces and linkages.

Quality - development of N.H. Medicaid program benchmark and outcomes measures; implementation of provider and client satisfaction surveys; and development of provider profiles that would support the implementation of a pay for performance program based upon achieving specific performance standards.

Training – training of staff, providers, clients and other stakeholders as needed.

The Process
Research and Outreach

- March 2005 Enhanced Care Coordination Advisory Workgroup
  - Recommendations made for improving Medicaid program
- August 2005 DHHS Project Team created
- Stakeholder meetings from August through present
  - Medical Care Advisory Committee; Home Care Association, BiState Primary Care Association; NH Hospital Association; Dartmouth – Hitchcock Southern Tier Medical Directors
- Presentation to the Legislative HHS Oversight Committee
- Public Forum 12/15/05
- Three presentations to the Legislative Fiscal Committee

RFP Process

- Will seek input from and keep Governor, Legislature, Fiscal and HHS Committees, & Executive Council advised on progress throughout process
- Received consultation from Dept of Administrative Services and Office of the Attorney General
- Hired expert consultant to assist with RFP and selection process.
- Review of Proposals
  - Deliverable: Recommendation for vendor to fulfill role of NH Medicaid Administrative Agent
  - Pre-selected and approved review team comprised of core team, team leader, and subject matter experts
    - Suggestions welcomed
  - Will be asked to sign confidentiality and conflict of interest statement to participate

The Contract

- Performance-based contract, risk relationship
- 3 year contract with option to extend
- Retention of portion of monthly reimbursement pending review of vendor report card

The Recommended Contractor

- Will be required to furnish performance bond for faithful performance on contract
  - Minimum of 2-5 years experience in design, development, implementation and operations of large, medical management, utilization management, disease management and other similar clinical based programs
  - Experience in administration of large health care delivery systems, provider management and credentialing particularly for the public sector
  - NCQA or URAC Certified and CMS certified as a QIO entity
  - Will be required to have local presence in-state

Payment of NHMAA Contract

- From provider payments account
- Total price to be quoted in terms of
  - Total Gross Dollars Saved
  - Total Net Administrative Costs
  - Total Savings to State
- Require detailed explanation of methodology used to calculate savings
  - Identify programmatic and financial assumptions
  - DHHS to conduct independent evaluation of financial proposals

Proposed Timeline
(Required to meet SFY ’07 Savings Objectives)

- Release RFP – Target February 2006
- Proposals due – March 2006
- Contract to G&C – June 2006
- Contract implementation – July 1, 2006
  - Design, Development and Implementation through January 2007
  - Full Operations and Evaluation begins January 2007 and then on-going
    - Consider seeking appropriation as part of SFY 08 budget to conduct independent quality assurance audit of DHHS care coordination program

Q&A

Additional comments can be mailed to:

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Or

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